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February 8, 2011

**TO:** Interested Parties

**FROM:** Russell J. Begin, Acting Director, MaineCare Services

**SUBJECT: Adopted Rule:** Chapter 101, MaineCare Benefits Manual, Chapter II Section 97, Private Non-Medical Institutions and Chapter III Appendix B: Principles of Reimbursement for Substance Abuse Treatment Facilities

This letter gives notice of an adopted rulemaking: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 97, Private Non-Medical Institution Services and Chapter III Appendix B: Principles of Reimbursement for Substance Abuse Treatment Facilities.

These changes were adopted on an emergency basis effective November 15, 2010. Pursuant to the supplemental budget, P.L. 2009, ch. 571, Section A-26 this rulemaking standardizes and reduces rates for services covered under Private Non Medical Institution Chapter III Appendix B. These rate reductions are necessary in order to implement those provisions of the Supplemental Budget over which the Department has subject matter jurisdiction. The amendments eliminate the interim rate/cost settlement method of reimbursement for substance abuse treatment facilities and replace that method with fixed per diem rates for each type of service. The amendments supply appropriate billing codes. In addition, Chapter II, Section 97 is amended to coordinate with changes to Chapter III regarding the method of reimbursing providers for these services. Minor revisions are made to the names of some services.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, [http://www.maine.gov/dhhs/bms/rules/provider\\_rules\\_policies.htm](http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm) or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

## Notice of Agency Rule-making Adoption

**AGENCY:** Department of Health and Human Services, Office of MaineCare Services

**CHAPTER NUMBER AND TITLE:** Chapter 101, MaineCare Benefits Manual, Chapter II Section 97, Private Non-Medical Institution Services, Chapter III Section 97, Private Non-Medical Institution Services Appendix B: Principles of Reimbursement for Substance Abuse Treatment Services

**ADOPTED RULE NUMBER:**

**CONCISE SUMMARY:** The amendments to Chapter III, Section 97 change the method of reimbursing PNMI substance abuse treatment facilities from an interim rate/cost-settlement basis to fixed per diem rates depending on the type of service. The new standardized rates are set forth in the regulation, and appropriate, HIPAA compliant billing codes are provided. Chapter II, Section 97 is amended to coordinate with changes to Chapter III regarding the method of reimbursement for these services. Minor revisions are made to the names of some services. The changes are necessary to meet budget reduction targets. The Legislature ordered various reductions in expenditures in the MaineCare program to counteract predicted deficits and balance the budget. P.L. 2009, ch. §571. The reduction in reimbursements for PNMI substance abuse treatment facilities was selected by the Legislature after careful consideration, and it will be implemented in a fair and equitable manner. It is anticipated that the proposed changes will result in savings of \$264,744 in State fiscal year 2011. These changes were first adopted by emergency rule effective November 15, 2010.

See [http://www.maine.gov/bms/rules/provider\\_rules\\_policies.htm](http://www.maine.gov/bms/rules/provider_rules_policies.htm) for rules and related rulemaking documents.

**EFFECTIVE DATE:** February 13, 2011

**AGENCY CONTACT PERSON:** Margaret Brown, Health Planner

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**97.01 DEFINITIONS**

**97.01-1 Authorized Agent**

Authorized Agent is the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions for the Department pursuant to a signed contract or other approved signed agreement, including but not limited to conducting prior authorization, clinical review, and concurrent review of services.

**97.01-2 Family**

Unless defined otherwise in the Principles of Reimbursement of Chapter III, Section 97, family means any of the following: spouse of the member, the parents or stepparents of a minor child, or a legally responsible relative.

**97.01-3 Individual Service Plan**

An Individual Service Plan (ISP) means the plan of service based on an individual assessment of a member's need for treatment or rehabilitation services made in accordance with the appropriate Principles of Reimbursement. Unless otherwise specified in the appropriate Principles of Reimbursement, this plan shall specify the service components to be provided, the frequency and duration of each service component, and the expected short and long range treatment and/or rehabilitative goals or outcome of services. Discharge planning must be addressed in the Individual Service Plan.

**97.01-4 Interim Per Diem**

A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMI, Section 2400 and the applicable Appendix) that may be paid to a PNMI provider for the provision of covered services. The interim per diem rate will be adjusted at audit.

**97.01-5 Medical Eligibility Determination (MED) Tool**

Medical Eligibility Determination (MED) Tool means the form approved by the Department for medical eligibility determinations and service authorization for the plan of care based upon the assessment outcome scores. The definitions, scoring mechanisms and time-frames relating to this form are outlined in Chapter II, Section 96.02-4. (The Form can be found at <http://www.maine.gov/dhhs/oes/medxx/medxx.htm>)

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97.01 **DEFINITIONS** (cont.)

97.01-6 Medical Supplies and Durable Medical Equipment

Unless defined otherwise in the Principles of Reimbursement, medical supplies and durable medical equipment means medically necessary supplies and equipment listed in Chapter II, Section 60, Medical Supplies and Durable Medical Equipment of the MaineCare Benefits Manual (MBM). All equipment must be directly related to member medical needs as documented in the individual service plan.

97.01-7 Per Diem Rate

A per diem rate is the rate determined by the Department of Health and Human Services (DHHS) (per Chapter III, Principles of Reimbursement for PNMI, Section 2400 and the applicable Appendix) paid to a PNMI provider for the provision of covered services.

97.01-8 Prior Authorization

Prior Authorization (PA) is the process of obtaining prior approval as to the medical necessity and eligibility for a service. Prior Authorization is also detailed in Chapter I of the MaineCare Benefits Manual (MBM). Crisis stabilization services do not require prior authorization, but providers must contact the Department within 48 hours to complete the prior authorization process for reimbursement of continued services. Other PNMI services require prior authorization as detailed in this Section.

97.01-9 Private Non-Medical Institution

A Private Non-Medical Institution (PNMI) is defined as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four or more residents in single or multiple facilities or scattered site facilities. Private Non-Medical Institution services or facilities must be licensed by the Department of Health and Human Services, or must meet comparable licensure standards and/or requirements and staffing patterns as determined by the Department specified in Section 97.01 (A-F). For agencies serving persons with mental retardation in scattered site PNMI, comparable licensure standards means those required by rule for community support services as described in Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug Treatment Services.

Services provided out-of-state must be medically necessary and unavailable in the State of Maine, and may be subject to approval by the Commissioner of the Department of Health and Human Services or designee, as well as prior

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97.01 **DEFINITIONS** (cont.)

authorization as described in this Section and Chapter I of the MaineCare Benefits Manual. The following details those services in Chapter III, Section 97:

Appendix B. Substance Abuse Treatment Facility

A substance abuse treatment facility is a PNMI that is maintained and operated for the provision of residential substance abuse treatment and rehabilitation services, and is licensed and funded by the Department's Office of Substance Abuse. Substance abuse treatment facilities are also subject to rules in MBM, Chapter III, Section 97, and Appendix B.

Appendix C. Medical and Remedial Services Facility

Medical and remedial services facilities are those facilities as defined in 22 MRSA §7801 that are maintained wholly or partly for the purpose of providing residents with medical and remedial treatment services and licensed by the Department of Health and Human Services under the "Regulations Governing the Licensing and Functioning of Assisted Living Facilities." These facilities must also be qualified to receive cost reimbursement for room and board costs not covered under this Section.

Medical and remedial facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix C.

Appendix D Child Care Facilities

A child care facility is any private or public agency or facility that is maintained and operated for the provision of child care services, as defined in 22 MRSA §8101, 8101(1), and 8101(4), is funded and licensed by the Department of Health and Human Services under the "Rules for Licensure of Residential Child Care Facilities," 10-148 CMR, Chapter 18; and/or is licensed and funded by the Department's Children's Behavioral Health Services pursuant to 34-B MRSA§3606.

Requests for exceptions to Department funding and licensure requirement may be made through written correspondence to the Office of MaineCare Services. Providers may make requests for exceptions to the Department of Health and Human Services funding and/or licensure requirement through written correspondence to the Office of MaineCare Services from the Office of Child and Family Services.

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97.01 **DEFINITIONS** (cont.)

For the purpose of MaineCare reimbursement only, child care facility Private Non-Medical Institutions also include treatment foster homes, their staff and parents, licensed by the Department, and child placing agencies under contract with the Office of Child and Family Services. Child placing agencies must be licensed in accordance with the rules providing for the licensing of child placing agencies. Child care facilities are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, and Appendix D.

Intensive Temporary Residential (ITRT) Treatment Services:

Intensive Temporary Residential Treatment Services (ITRT) are defined as child care facility private non-medical institution model of service services for children with mental retardation, autism, severe mental illness, and/or emotional disorders, who require twenty-four (24) hour supervision to be safely placed in their home and community. ITRT must be provided in the least restrictive environment possible, with the goal of placement as close to the child's home as possible. Families must remain as actively involved in their child's care and treatment as possible. The purposes of ITRT are to provide all services to both treat the mental illness/disorder and to return the child to his/her family, home and community as soon as possible.

ITRT provide twenty-four (24) hour per day, seven (7) days per week structure and supportive supervised living environment and active behavioral treatment, as developed in a treatment plan. This environment is integral to supporting the learning experiences necessary for the development of adaptive and functional behavior to allow the child to live outside of an inpatient setting.

ITRT are also subject to rules in MBM, Chapter III, Section 97, and Appendix D.

Appendix E. Community Residences for Persons with Mental Illness

A community residence PNMI is a PNMI with integral mental health treatment and rehabilitative services, that is licensed by the Department, funded as a mental health residential treatment or supportive housing service by DHHS, Adult Mental Health, and operated in compliance with treatment standards established



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97.01 **DEFINITIONS** (cont.)

through these rules and the pertinent Principles of Reimbursement.

Community residences for persons with mental illness also include residential services for the integrated treatment of persons with dual disorders, which provide mental health and substance abuse treatment services to individuals with coexisting disorders of mental illness and substance abuse. These residences shall be licensed by the Department. Such residences must also be receiving funds from the Department for the treatment of persons with dual disorders. Community residences for persons with mental illness are also subject to rules in MBM, Chapter III, Section 97, and Chapter III, Section 97, Appendix E.

Appendix F. Non-Case Mixed Medical and Remedial Facilities

Non-case mixed facilities provide PNMI medical and remedial treatment services to members in specialized facilities or scattered site facilities not included in the case mix payment system described in Appendix C. These facilities specialize in solely treating members with specific diagnoses such as acquired brain injury, HIV/AIDS, mental retardation, or blindness. Services must be provided in compliance with these rules, the pertinent Chapter III, Principles of Reimbursement, and Chapter III, Appendix F, and any contractual provisions of the Department.

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97.01 **DEFINITIONS** (cont.)

97.01-10 Private Non-Medical Institution Services

Private Non-Medical Institution services are those services provided to a member at one of the above properly licensed and/or designated institutions, in accordance with these regulations, and in accordance with the pertinent Principles of Reimbursement established by the Department of Health and Human Services.

97.01-11 Program Allowance

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A program allowance, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400.1 and 2400.2 may be allowed in lieu of indirect and/or PNMI related cost. See applicable Chapter III section and appendix.

97.01-12 Provider Agreement

A provider agreement encompasses the MaineCare Provider Agreement on file with the Office of MaineCare Services. Providers must also contract with the Department and satisfactorily meet all contract and provider agreement provisions.

97.01-13 Rate Letter

A rate letter is an instrument used to inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Chapter III, Section 2400, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the industry price, program allowance, personal care services component, and average case mix index.

97.01-14 Utilization Review

Utilization Review (UR) is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent, or retrospective basis.

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**97.02 ELIGIBILITY FOR CARE**

**97.02-1 General Eligibility Criteria**

The following individuals are eligible for medically necessary covered Private Non-Medical Institution services as set forth in this Manual:

Individuals must meet the basic eligibility criteria as set forth in Part 2 of the MaineCare Eligibility Manual, 10-144 CMR Chapter 332. There are restrictions on the type and amount of services that members are eligible to receive and they must meet specific eligibility criteria detailed below.

**97.02-2 Medical Necessity**

Services in PNMI's must be medically necessary, as evidenced by meeting the medical eligibility criteria set forth in this section. A physician or primary care provider must also document in writing that this model of service is medically necessary for the member, and both the physician and the PNMI provider must keep this documentation in the member's file. For all PNMI services, this documentation must be completed as part of the prior authorization process conducted by the Department and/or its Authorized Agent.

**97.02-3 Medical Eligibility for Appendix B: Substance Abuse Facilities**

Members must require residential substance abuse treatment as assessed by the provider, and documented in the individual service plan and member's file using the following criteria: American Society of Addiction Medicine, ASAM Patient Criteria for the Treatment of Substance Abuse Disorder, Second Edition, revised (2001), Level III, Residential/Inpatient Treatment Criteria. Members must continue to meet Level III for continued eligibility.

The Department or its Authorized Agent will conduct utilization review to assure medical necessity of these services.

**97.02-4 Prior Authorization and Medical Eligibility for Appendix C: Medical and Remedial Facilities**

Appendix C facilities must contact the Department's Office of Elder Services, who must verify that members meet the medical eligibility requirements for residential care as indicated by the Medical Eligibility Determination (MED) tool assessment.

A member meets the medical eligibility and admission criteria for Appendix C PNMI only if that person meets one or more of the following eligibility requirements:

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**97.02 ELIGIBILITY FOR CARE (cont.)**

- Requires cuing seven (7) days per week for eating, toilet use, bathing, and dressing; OR
- Requires limited assistance and a one (1) person physical assist with at least two (2) of the seven (7) activities of daily living (ADLs) including bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing; OR
- Requires preparation and administration of regularly scheduled prescribed medications two (2) or more times per day that is or otherwise would be performed by a person legally qualified to administer prescribed medications; OR
- Requires any of the following nursing services, at least once per month, that are or otherwise would be performed by or under the supervision of a registered professional nurse, as described below:
  - administration of treatments, procedures, or dressing changes which involve prescribed medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring. These treatments include:
    - administration of medication via a tube;
    - tracheostomy care;
    - urinary catheter change;
    - urinary catheter irrigation;
    - barrier dressings for Stage 1 or 2 ulcers;
    - chest Physical Therapy (PT) by RN;
    - oxygen therapy by RN; or
    - other physician ordered treatments; OR
- Professional nursing assessment, observation, and management for problems including wandering, physical or verbal abuse or socially inappropriate behavior; OR
- Professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; OR
- Exhibits moderately to significantly impaired decision-making ability that will result in reasonably foreseeable unsafe behavior when not appropriately supervised as measured by the cognition section of the MED tool; OR

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**97.02 ELIGIBILITY FOR CARE (cont.)**

- Presents an imminent risk of harm or a probable risk of significant deterioration, as determined by the Department or the Department's Authorized Agent, of the individual's physical, mental or cognitive condition if the individual resides or would reside outside of a licensed facility.

**97.02-5 Prior Authorization Requirements for Appendix D Child Care Facilities**

All children's services under this Section with the exception of crisis services require prior authorization using eligibility criteria set forth in these rules.

Providers must submit all documentation required for prior authorization according to the guidelines of this Section and Chapter I of this Manual to the appropriate Department Regional Office of the Office of Child and Family Services.

All required assessment tools must be completed within the last ten(10) days prior to submission of the prior authorization request. The DHHS Intensive Temporary Residential Treatment Team (ITRT) in each Region will review the information submitted to determine whether the child meets the criteria set forth below. The Team will determine the child's level of severity and recommend appropriate providers who can meet the needs of the child.

Providers must obtain prior authorization for current residents using these same assessments at the next continuing stay review. Reassessment is required to assure that medical necessity criteria are met for continuing stay in either Level I or Level II programs. Each prior authorization letter sent to the provider and the child/guardian shall indicate the model of service the child is eligible for.

Children must be assessed using the tools mentioned below and providers must submit all requested documentation to the appropriate Department Regional Office of Child and Family Services. Failure to submit requested information will result in disapproval of the prior authorization request. The Department will not reimburse for services that have not been prior approved.

Crisis service providers must contact the Department within 48 hours of initiation of service to begin the prior authorization process for continued provision of services.

Any change in a child's location or program within an agency or to another agency requires prior authorization.

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**97.02 ELIGIBILITY FOR CARE (cont.)**

**97.02-6 Assessment Tools for Appendix D Child Care Facilities**

The following assessment tools are used in assessing eligibility for Children's PNMI services, though none of the tools are used as the sole determinant of eligibility.

Children's Habilitation Assessment Tool (CHAT) assesses functioning in three domains: behavior, social skills, and life skills using interviews for individuals 6 to 18 years of age diagnosed with mental retardation or a pervasive developmental disorders.

Child and Adolescent Functional Assessment Scale (CAFAS) assesses the functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems in individuals 6 through 17 years of age. A trained rater completes the scale.

Global Assessment Functioning (GAF) is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate social, occupational and psychological functioning, e.g., how well or adaptively one is meeting various problems-in-living. Children and adolescents under the age of 18 may be evaluated on the Children's Global Assessment Scale, or C-GAS, and for infants, the Parent-Infant Relationship Global Assessment Scale (PIR-GAS) PIR-GAS version is utilized.

Preschool and Early Childhood Functional Assessment Scale (PECFAS) Assesses functioning related to behavioral, emotional, psychological, or psychiatric problems for children 3 to 7 years of age who are not enrolled in a full-day kindergarten or first grade. A trained rater completes the scale.

**97.02-7 Medical Eligibility Criteria for Appendix D Child Care Facility Services**

There are five models of PNMI services for Appendix D Child Care Facilities:

1. Mental Retardation and Pervasive Developmental Disorder (PDD)  
Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

There are two levels of PNMI services for children with mental retardation and/or PDD and other symptoms requiring this intensity of service. A child is eligible for only one level of service at a time. Initial prior authorization will not be given for more than thirty days at a time and continuing stay will be assessed at a minimum of every ninety days thereafter.

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**97.02 ELIGIBILITY FOR CARE (cont.)**

All of the following criteria set forth below must be met, in addition to criteria for either Level I or Level II services, as detailed below. The child must have:

- An Axis I or II diagnosis from the most current version of the DSM, and
- A disorder that has lasted for at least six (6) months or is expected to last for at least one (1) year in the future, and
- A current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- A disorder that is amenable to treatment in a residential setting, and
- even with intensive community intervention, including services and supports, there is significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.

In addition to the above criteria, the child must meet the following criteria for either Level I or Level II services:

Level I Criteria:

- Significant recent aggression across multiple environments or severe enough within one environment to have caused serious injury or there is significant potential of serious injury to self or others; or
- Recent homicidal ideation with risk of harm to others, or
- Recent suicidal ideation with risk of harm to self; or

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**97.02 ELIGIBILITY FOR CARE (cont.)**

- Symptoms of mental retardation or Pervasive Developmental Disorder so severe that it results in an inability to care for oneself to a developmentally appropriate level even with home and community supports and services; or
- Has not responded to less restrictive level of care or would have a significant risk of harm to self or others if a less restrictive setting were attempted; and
- An assessment using the Children's Habilitation Assessment Tool (CHAT) with a score of 30 or higher or Global Assessment Functioning (GAF) tool score of 50 or lower with description of specific symptoms justifying the score.

Level II Criteria

- The Child must meet all the level I service criteria and in addition:
- Frequency, intensity and duration of intervention required to address daily repeated aggression and potential for harm to self or others, or
- Frequency, intensity and duration of assistance required to address activities of daily living and
- potential for harm to self or others either directly or as a consequence of being unable to maintain ADL's and
- Children's Habilitation Assessment Tool (CHAT) score of 35 or higher, or a Global Assessment Functioning (GAF) score of 40 or lower with description of specific symptoms justifying the score.



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**97.02 ELIGIBILITY FOR CARE (cont.)**

2. Child Mental Health Conditions: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

There are two levels of PNMI services for children and adolescents with Mental Health Conditions.

The child must meet all of the criteria set forth below:

- The child must have either an Axis I or II diagnosis from the most current version of the DSM, and
- The child's disorder has lasted for at least six (6) months or is expected to last for at least one year in the future, and
- The child has a current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- The child's disorder is amenable to treatment in a residential setting, and
- Even with intensive community intervention, including services and supports, there is significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.

In addition, the child must meet the criteria below for Level I or Level II services:

Level I Criteria:

- Significant recent aggression across multiple environments or severe enough within one environment to have caused injury or there is significant potential of injury to self or others; or
- Recent homicidal ideation with risk of harm to others, or
- Recent suicidal ideation with risk of harm to self; or

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**97.02 ELIGIBILITY FOR CARE (cont.)**

- Symptoms of mental illness so severe that it results in an inability to care for oneself in a developmentally appropriate manner, even with home and community supports or services; or
- Has not responded to less restrictive model of service or would have a significant risk of harm to self or others if a less restrictive setting were attempted; and
- A Child and Adolescent Functional Assessment Scale (CAFAS) score of 100 or higher or Global Assessment Functioning (GAF) score of 50 or lower with description of specific symptoms justifying the score.

Level II Criteria

- Frequency, intensity and duration of intervention required to address daily repeated aggression and potential for harm to self or others, or
- Frequency, intensity and duration of assistance required to address Activities of Daily Living and potential for harm to self or others either directly or as a consequence of being unable to maintain ADL's and
- A Child and Adolescent Functional Assessment Scale (CAFAS) 8 scale score of 120 or higher, or Global Assessment Functioning (GAF) score of 40 or lower with description of specific symptoms justifying the score.

**97.02 ELIGIBILITY FOR CARE (cont.)**

**A. Temporary High Intensity Service for Child and Adolescent Intensive  
Temporary Behavioral Health Treatment in Residential Setting**

**FOR 1) MENTAL RETARDATION AND PERVASIVE  
DEVELOPMENTAL DISORDER CONDITION PROVIDERS AND 2)  
CHILD MENTAL HEALTH CONDITION PROVIDERS ONLY:**

The purpose of this temporary service is to stabilize a child who is currently residing in an Appendix D PNMI and experiences an escalation in behavioral discontrol in order to avoid the need to hospitalize the child. This service, provided only in an Appendix D PNMI for the express purpose of maintaining a child in the PNMI program, must be Prior Authorized and will be subject to Continuing Stay Review no later than every seven (7) calendar days. An Individualized Treatment Plan detailing the issue that has caused this request to be made must be submitted to the OCFS regional Intensive Treatment Review Team with the request for Prior Authorization that demonstrates why the child or others are not safe without this level of service, changes in treatment in an effort to decrease the unsafe behaviors, and documents a discharge plan with specific discharge criteria from this level of service.

The typical length of service is no more than seven (7) days and should not exceed thirty (30) days. In situations where this Level is sought for thirty (30) days or more, a Continuing Stay Review will be required and a new program considered that would more appropriately meet the child's needs.

The child must meet all eligibility criteria set forth below. The child must meet eligibility criteria for

- a. Mental Retardation and Pervasive Developmental Disorder  
Conditions Level I or II; OR
- b. Child Mental Health Conditions Level I or II,

AND

**97.02 ELIGIBILITY FOR CARE (cont.)**

c. The child must have extreme needs that would otherwise result in immediate hospitalization or placement in an out-of-state institution due to immediate serious repeated physical harm to self or others or immediate risk of repeated serious physical harm to self or others that could not otherwise be predicted or planned for at the time of admission. This level of care is not intended as a first response to aggression but as a last resort when other clinical and medical interventions have been exhausted. Brief hospitalizations for medication and behavioral stabilization are not grounds for seeking this level of care.

**3. Intensive Mental Health Service for Infants and/or Toddlers**

The criteria set forth below are minimum standards for eligibility for treatment for this program that is only for infants or toddler birth through age five (5).

Infants/toddlers must exhibit:

- Failure to respond to less restrictive model of service or there would be a significant risk of harm if a less restrictive setting were attempted; and
- A Preschool and Early Childhood Functional Assessment Scale (PECFAS) 8 scale score of 100 completed within ten (10) days of submission for Prior Authorization, or DC 0-3R Parent-Infant Relationship Global Assessment Scale (PIR-GAS) Axis II of 60 or lower or other tools approved by the Department, and
- The infant/toddler must also meet all of the criteria set forth below:
  - an Axis I or II diagnosis from the most current version of the DSM, or
  - an Axis I diagnosis from the most current version of the DC 0-3R, and
  - The disorder has lasted for at least six (6) months or is expected to last for at least one year in the future, and

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97.02 **ELIGIBILITY FOR CARE (cont.)**

- The infant/toddler must have a current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- The disorder must be amenable to treatment in a residential setting, and
- Even with intensive community intervention, including services and supports, there is significant potential that the infant/toddler will be hospitalized, or there is a clear indication that the infant/toddler's condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.

4. Crisis Stabilization Residential Services Crisis Stabilization services are individualized therapeutic interventions provided to a child during a psychiatric emergency to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post-crisis period, in order to stabilize the member's condition. Psychiatric emergency is when the child is in imminent risk of serious harm to self or others and even with intensive community intervention, including services and supports, there is significant potential that the member will be hospitalized.

Components of crisis stabilization include assessment, monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and implementing crisis and post stabilization activities, and supervising the child to assure personal safety.

While crisis services do not require prior authorization, providers must contact the Department within forty eight (48) hours to get approval of continued reimbursement for this service using the prior approval process detailed in this Section.

97.02 **ELIGIBILITY FOR CARE (cont.)**

5. Therapeutic Foster Care: Child and Adolescent Intensive Temporary Behavioral Health Treatment in a Residential Setting

Therapeutic Foster Care is a family based service delivery approach providing treatment to children with moderate to severe mental health, behavioral health and developmental needs. Treatment is delivered through services integrated with key interventions and supports provided by therapeutic foster parents who are trained supervised and supported by qualified therapeutic foster care program staff. The delivery of treatment is a shared responsibility between the independently licensed clinical staff, the independently licensed social work staff and the therapeutic foster parents. Therapeutic foster care is designed to allow children receiving treatment to reside in a family like setting as opposed to institutional settings, while receiving treatment.

To be eligible for these services, the child must be in DHHS or Department of Corrections custody and must require therapeutic intervention detailed above.

The child must meet the following criteria:

- A Child and Adolescent Functional Assessment Scale (CAFAS) 8 scale score of 50 higher, and
- an Axis I or II diagnosis from the most current version of the DSM, and
- The child's disorder must have lasted for at least six (6) months or is expected to last for at least one year in the future, and
- A current need for therapeutic treatment or availability of a therapeutic on-site staff response on a twenty-four hour basis, and
- Even with intensive community intervention, including services and supports, significant potential that the child will be hospitalized, or there is a clear indication that the child's condition would significantly deteriorate and would require a higher model of service than can be provided in the home and community.

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**97.02 ELIGIBILITY FOR CARE (cont.)**

**97.02-8 Prior Authorization and Medical Eligibility for Appendix E: Community Residences For Persons With Mental Illness**

Appendix E services require prior authorization and utilization review. Providers must submit all eligibility documentation required for prior authorization according to the guidelines of this Section and Chapter I of the MaineCare Benefits Manual to the DHHS Office of Adult Mental Health Services. No PNMI provider may admit a member into an Appendix E facility without prior authorization. To be eligible, members must meet the following eligibility criteria, with documentation of all of the following information in the member's care plan:

a. Assessment Tools Used for Prior Authorization:

Providers must use the Department's approved assessment tool, the Level of Care Utilization System for Psychiatric and Addiction Services, Adult Version 2010, of the American Association of Community Psychiatrists (LOCUS) as a tool in assessing eligibility.

b. Eligibility Criteria:

Members must meet the following eligibility criteria, with documentation of all of the following information in the member's plan:

The person is age eighteen (18) or older or is an emancipated minor;

AND

Has a primary diagnosis on Axis I or Axis II of the multiaxial assessment system of the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, other than one of the following diagnoses: Delirium, dementia, amnesia, and other cognitive disorders; Mental disorders due to a general medical condition, including neurological conditions and brain injuries; Substance abuse or dependence; developmental disabilities; Adjustment disorders; V-codes; or Antisocial personality disorder;

AND

demonstrates a need for residential care as assessed by the LOCUS with a score on the LOCUS of at least 23 or greater and a Level V or more.

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**97.02 ELIGIBILITY FOR CARE (cont.)**

**97.02-9 Prior Authorization and Medical Eligibility Criteria for Appendix F: Non-Case Mixed Facilities**

Non-Case Mixed Medical and Remedial Facilities specialize in the treatment of adults with mental retardation, brain injury, mental illness, or other disabilities.

No PNMI provider may admit a member into an Appendix F mental health facility without prior authorization. Appendix F Non-Case Mixed facilities must contact the Department of Health and Human Services as detailed below to obtain prior authorization for services:

Those facilities serving public wards must contact the Office of Elder Services Adult Protective Services Regional Offices for authorization for placement of any member in an Appendix F facility serving public wards. For all other Appendix F facilities contact the Office of Adults with Physical and Cognitive Disabilities to assure that services are prior authorized.

**1. Medical Eligibility Criteria for Persons Treated in Facilities Specializing in Treatment of Mental Illness:**

Facilities serving members with mental illness in an Appendix F facility must submit all eligibility documentation required for prior authorization according to the guidelines of this Section and Chapter I of the MaineCare Benefits Manual to the DHHS Office of Adult Mental Health Services. To be eligible, members must meet the following eligibility criteria, with documentation of all of the following information in the member's care plan:

**a. Assessment Tools Used for Prior Authorization:**

Providers must use the Department's approved assessment tool in assessing eligibility, the LOCUS, which is the Level of Care Utilization System for Psychiatric and Addiction Services of the American Association Services. The Adult Version 2000 will be utilized until DHHS has authorization to use the Adult 2010 version.

**b. Eligibility Criteria:**

Members must meet the following eligibility criteria, with documentation of all of the following information in the member's plan:



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**97.02 ELIGIBILITY FOR CARE (cont.)**

The person is age eighteen (18) or older or is an emancipated minor;

AND

Has a primary diagnosis on Axis I or Axis II of the multiaxial assessment system of the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, other than one of the following diagnoses: Delirium, dementia, amnesia, and other cognitive disorders; Mental disorders due to a general medical condition, including neurological conditions and brain injuries; Substance abuse or dependence; developmental disabilities; Adjustment disorders; V-codes; or Antisocial personality disorder;

AND

demonstrates a need for residential care as assessed by the LOCUS with a score on the LOCUS of at least 23 or greater and a Level V or more.

2. Medical Eligibility Criteria for Persons Treated in Facilities Specializing in Treatment of Brain Injuries:

To be eligible for services in facilities specializing in treatment of brain injury, members must meet the following eligibility criteria, with documentation of all of the following information in the member's individual service plan:

The person must be age eighteen (18) or older AND

Have a primary diagnosis of head injury, defined as "an insult to the brain resulting directly or indirectly from trauma, anoxia, vascular lesions or infection, which is not of a degenerative or congenital nature; can produce a diminished or altered stated of consciousness resulting in impairment of cognitive abilities or physical functioning; can result in the disturbance of behavioral or emotional functioning; can be either temporary or permanent; and can cause partial or total functional disability or psychosocial maladjustment" confirmed by a qualified neuropsychologist or a licensed physician who is Board certified or otherwise Board eligible, in either physical medicine and rehabilitation or neurology;

AND

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**97.02 ELIGIBILITY FOR CARE (cont.)**

Have cognitive, physical, emotional and behavioral needs resulting in a score of at least three (3) on one item in at least two (2) domains on the Brain Injury Assessment Tool (BIAT) administered by a qualified neuropsychologist or occupational therapist or speech/language pathologist or a licensed physician who is Board certified or otherwise Board eligible in either physical medicine and rehabilitation or neurology or other licensed professional authorized by Brain Injury Services;  
AND

Have a demonstrated need for twenty-four (24) hour supervision and support as indicated on the Brain Injury Health and Safety Assessment (BIHSA) administered by a qualified neuropsychologist or occupational therapist or speech/language pathologist or a licensed physician who is Board certified or otherwise Board eligible in either physical medicine and rehabilitation or neurology or other licensed professional authorized by Brain Injury Services.

Members with brain injuries receiving these services will be reassessed annually using the BIAT and BIHSA to determine continuing need for services. Members currently receiving these services will be assessed within 180 days of the implementation date of this rule.

Members no longer eligible for these services will be discharged only to a safe, appropriate residential arrangement.

**3. Medical Eligibility Criteria for Persons Treated in Facilities Specializing in Treatment of Members with Mental Retardation/ Pervasive Developmental Disorder**

In order to be eligible for services under this sub-section specializing in treatment for members with mental retardation and/or Pervasive Developmental Disabilities, members must be at least eighteen (18) years old  
AND:

meet the eligibility requirement for persons with mental retardation/pervasive developmental disorders as defined in 34-B M.R.S.A. Section 5001(3) and 6002. "Mental retardation" means a condition of significantly sub-average intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period."

AND

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**97.02 ELIGIBILITY FOR CARE (cont.)**

be in jeopardy of not having a place to live, or not adequate supervision necessary to assure their health and safety. This determination will be made based on the results of a risk assessment and supported by the member's planning team,

AND

Require that supervision be available and on-site at all times;  
AND

using the Department's Developmental Services Needs Inventory tool, have identified needs at the C,D, or E level in at least three of the categories. Providers may contact the Department to obtain this assessment tool.

**4. Eligibility for Other Medical and Remedial Facilities**

Some providers of Medical and Remedial Facilities treat members with a variety of medical needs not detailed above. To be reimbursed for services, providers must assure that members meet medical eligibility for at least one of the above Medical and Remedial Facility eligibility criteria detailed above including at a minimum the eligibility criteria for Appendix C or Appendix F above or eligibility as a public ward for Adult Protective Services as defined in 22 M.R.S.A Chapter 958-A.

**97.03 DURATION OF CARE**

Each MaineCare member is eligible for covered services that are medically necessary as determined by eligibility and continued eligibility requirements set forth in this Section. The Department reserves the right to request additional information to evaluate eligibility and continued eligibility for services.

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**97.04 COVERED SERVICES – DIRECT SERVICE STAFF**

A covered service is a service for which payment to a PNMI provider is permitted under the rules of this Section. Direct service staff is defined as staff who provide the services listed in this Section. MaineCare covers the following services when provided in an approved setting of a licensed Private Non-Medical Institution in accordance with Chapter III, Principles of Reimbursement for Private Non-Medical Institution Services, provided within the scope of licensure of the facility, and billed by that facility, and as identified in Section 97.08. Not all of the following services are included in the rate for every type of facility. Refer to the applicable Appendix in Chapter III for services that are included in the rate for each type of PNMI. The Chapter III Principles of Reimbursement for each type of Private Non-Medical Institution define which staff services are allowable. The service must be listed in the Principles of Reimbursement in order for the service to be reimbursable. Covered services may include, but are not limited to:

- 97.04-1 Physician services
- 97.04-2 Psychiatrist services
- 97.04-3 Psychologist services
- 97.04-4 Psychological examiner services
- 97.04-5 Social worker services
- 97.04-6 Licensed clinical professional counselor services
- 97.04-7 Licensed professional counselor services
- 97.04-8 Dentist services
- 97.04-9 Registered nurse services
- 97.04-10 Licensed practical nurse services
- 97.04-11 Psychiatric nurse services
- 97.04-12 Speech pathologist services
- 97.04-13 Licensed alcohol and drug counselor services
- 97.04-14 Occupational therapy services
- 97.04-15 Other qualified mental health staff services
- 97.04-16 Other qualified medical and remedial staff services
- 97.04-17 Other qualified alcohol and drug treatment staff services
- 97.04-18 Personal care services
- 97.04-19 Other qualified child care facility services
- 97.04-20 Other qualified licensed treatment foster care provider services
- 97.04-21 Interpreter services
- 97.04-22 Nurse practitioner services
- 97.04-23 Physician assistant services
- 97.04-24 Clinical consultant services
- 97.04-25 Physical therapy services

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**97.05 LIMITATIONS**

**97.05-1 Collateral Contacts**

Reimbursement shall be made for direct services, collateral contacts, and certain supportive services when there is not a direct encounter with the member, only as described in Chapter III, Principles of Reimbursement for PNMI, Section 2400, and when provided by qualified staff members.

**97.05-2 Non-Duplication of Services**

It is the responsibility of the PNMI provider to coordinate PNMI services with other "in-home" services to address the full range of member needs. Other MaineCare covered services shall not duplicate PNMI services included in the facility's PNMI rate. Covered services, listed in the applicable Appendix, and/or in contracts with the Department, that are part of the PNMI rate are the responsibility of the PNMI to provide or arrange under contract as necessary with providers practicing within the scope of their licensure.

Services that are part of the PNMI rate may not be billed to MaineCare separately by other providers. Personal care services are included as part of the PNMI rate and shall be delivered by the PNMI provider and not by a MaineCare provider under any other Section of this Manual including PSS under Section 96, Private Duty Nursing and Personal Care Services provider or other Section of MaineCare policy.

PNMI providers must coordinate their services with all other MaineCare services, including but not limited to case managers providing services outside the residential setting, in accordance with the provisions of Chapter II, Section 13, of the MaineCare Benefits Manual, Targeted Case Management Services.

**97.05-3 Out-of-State Placement**

Reimbursement shall not be made for Private Non-Medical Institution services provided out of state unless the services are medically necessary, and are not available within the State and prior authorization (as described in this Section and Chapter I, of the MaineCare Benefits Manual) has been granted.

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**97.04 COVERED SERVICES – DIRECT SERVICE STAFF (cont.)**

**97.05-4 Bed-Hold Days**

Bed-hold days are not reimbursable.

For members receiving State S.S.I. and cost-reimbursement benefits, in order for benefits to continue for a member who is temporarily admitted to a State institution, a hospital, or a nursing facility when the residential care facility provider has agreed to hold the bed, the provider must do the following: a) Notify the Social Security Administration that the member has been admitted to an institution, and b) Notify the Social Security Administration that the bed is being held for the resident.

**97.06 NON-COVERED SERVICES**

Please refer to Chapter I of the MaineCare Benefits Manual for additional non-covered services, including services that are for vocational, academic, socialization or recreational purposes.

**97.06-1 Private Room and Other Non-Covered Services**

The PNMI may permit payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room, telephone, television, or other non-covered services. However, the additional charge for non-covered services shall not exceed the charge to private pay residents. The supplement for a private room shall be no more than the difference between the private pay rate for a semi-private room and a private room rate. There shall be a signed statement by the member and/or relative making the additional payment that he/she was notified and agreed to the payment for non-covered services before those services were provided. This provision shall not apply where the standard of care in the PNMI is for a private room.

Private rooms, as are all PNMI room and board costs, are non-covered services under MaineCare, but if there is a medical necessity for a private room, the PNMI must make one available.

**97.06-2 Personal Care Services Provided by a Family Member**

Personal care services provided by a family member are not a covered service, and may not be billed by the family or by any other provider.

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**97.07 POLICIES AND PROCEDURES**

**97.07-1 Setting**

Services shall be delivered in the Private Non-Medical Institution or other settings appropriate to individual service needs in accordance with an individual service plan.

**97.07-2 Qualified Staff**

A Private Non-Medical Institution may be reimbursed for services provided by the following staff and as set forth in the Chapter III, Principles of Reimbursement for that type of institution:

**A. Professional Staff**

All professional staff must be conditionally, temporarily, or fully licensed and approved to practice as documented by written evidence from the appropriate governing body.

MaineCare may reimburse a PNMI for covered services as defined in Section 97.04 if they are provided by the following professional staff members: dentist, licensed alcohol and drug counselor, licensed clinical professional counselor, licensed professional counselor, nurse practitioner, occupational therapist registered, physician, physician assistant, licensed practical nurse, psychiatrist, psychiatric nurse, psychologist, psychological examiner, registered nurse, social worker, or speech language pathologist. All providers must hold appropriate licensure in the state or Province in which services are provided and must practice within the scope of these licensing guidelines. See Appendix D of Section 97, Chapter III, for PNMI covered services.

**B. Other Qualified Mental Health Staff**

Other staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. They have education, training, or experience that qualifies them to perform certain specified mental health functions;
2. They receive certification from the Department, or its designee, that they are qualified to perform such functions and such verification is recorded in writing and kept in the files of the Department, or its designee; and

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3. They perform such functions under the supervision of a licensed, certified, or registered health professional with the supervisory relationship having been described to and approved by the Department in accordance with its licensing and certification regulations.

C. Other Qualified Medical and Remedial Services Staff

Medical and remedial services and personal care services staff members may be considered qualified for purposes of this Section if they meet the following requirements:

1. The services they provide are prescribed by a physician and are in accordance with the member's plan of care.
2. The facility has written documentation that each staff person has received orientation or is currently in orientation in keeping with the licensing regulations for medical and remedial services facilities cited in Section 97.01-1(D) and is adequately performing medical and remedial services according to minimum standards set by the Office of MaineCare Services identified in the regulations cited above.
3. The medical and remedial services staff person is not a member of the member's family as defined in the Chapter III, Principles of Reimbursement for Medical and Remedial Service Facilities.

D. Other Qualified Alcohol and Drug Treatment Staff

Other qualified alcohol and drug treatment staff are staff members, other than professional staff defined above, who have appropriate education, training and experience in substance abuse treatment services, related disciplines as approved by the Office of Substance Abuse (OSA), or behavioral sciences; who work under a substance abuse treatment professional, consisting of at least one (1) hour per week for each twenty (20) hours of covered services rendered; and who are approved by the State Board of Alcohol and Drug Counseling as documented by written evidence on file with that office pursuant to Section 4.19 of the Regulations for Licensing/Certifying Substance Abuse Treatment Facilities in the State of Maine. A Certified Alcohol and Drug Counselor is considered to be an other qualified substance abuse staff member.



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**97.07 POLICIES AND PROCEDURES (cont.)**

**E. Personal Care Service Staff**

Personal care service staff may be considered qualified for purposes of this Section if they meet the following requirements:

1. The personal care services provided by all PNMI's are prescribed by a physician upon or within thirty (30) days of admission, are in accordance with the member's plan of care, are supervised by a registered nurse at least every ninety (90) days, and are not provided by a member of the member's family as described in Section 97.01-6 or the pertinent Appendix of Chapter III, Principles of Reimbursement.
2. The following facilities shall have written documentation that each staff person has received orientation in keeping with the licensing regulations for: a) community residences for people with mental illness, cited in Section 97.01-1(C) or, b) as outlined in the residential services agreement required by the Department of Health and Human Services licensing requirements cited in Section 97.01-1 (E); or c) in accordance with licensing regulations for residential substance abuse treatment PNMI's as cited in Section 97.01-1(A).

Alcohol and drug treatment PNMI's shall maintain documentation that each staff member providing such services has received forty (40) hours of orientation and training in personal care procedures appropriate to residents.

Areas of training must include introduction to chemical addictions, assistance in self administration of medication, infection control, bowel and bladder care, nutrition, methods of moving patients, and health oriented record keeping.

Personal care service staff shall adequately perform personal care services according to minimum standards set by the Department when providing services in community residences for people with mental illness.

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F. Other Qualified Child Care Facility Staff

Other qualified child care facility staff are those individuals who have appropriate education, training, attributes, and experience as approved by the Office of Child and Family Services (OCFS). The PNMI shall submit to the OCFS for approval, names and qualifications of personnel defined as other qualified child care staff in the format provided by that Office.

1. In order to qualify for reimbursement for other qualified child care facility staff, the PNMI shall provide written evidence on file with the provider that other qualified child care facility staff shall meet the standards outlined in the certification requirements established by the OCFS as documented by written evidence on file with that Office.
2. Other qualified child care staff, when performing PNMI reimbursable services, shall receive regular, documented supervision by appropriately licensed or certified staff in accordance with the Rules for Licensure of Residential Child Care Facilities, (or in the case of facilities also licensed by the Office of Substance Abuse, Licensed Alcohol and Drug Counselors).

G. Other Qualified Licensed Treatment Foster Care Providers

Other qualified licensed treatment foster care providers are licensed treatment foster care homes/parents who hold a contract to provide treatment foster care services to State agency clients.

H. Interpreter Services

See Chapter I for provider rules regarding Interpreter Services.

I. Clinical Consultant Services

Clinical consultant services must be provided by licensed or certified professionals as described in Chapter II, Section 97.07-2, of these rules, and working within all State and Federal regulations specific to the services provided.

For those facilities covered under Chapter II, Appendix B, substance abuse facilities, clinical consultants may include substance abuse services including methadone maintenance services.

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97.07 **POLICIES AND PROCEDURES** (cont.)

97.07-3 Assessment and Individual Service Plan

Qualified staff must provide reimbursable services following a written individual service plan. The service plan must be developed and reviewed in accordance with these rules for either substance abuse treatment facilities, child care facilities, community residences for persons with mental illness, medical and remedial services facilities, non-case mixed medical and remedial facilities, or ITRT facilities. PNMI staff must assess members for unmet physical and mental health needs, and complement the individual service plan with appropriate referrals for health care.

97.07-4 Member's Record

The provider must keep a record for each member that includes, as applicable, but is not necessarily limited to:

- A. The member's name, address, and birthdate;
- B. The member's medical and social history, as appropriate;
- C. The member's diagnosis. The attending physician or psychiatrist, if applicable;
- D. Long and short range medical and other goals, as appropriate;
- E. A description of any tests ordered by the PNMI and performed and results;
- F. A description of treatment, counseling, or follow-up care;
- G. Notation of any medications and/or supplies dispensed or prescribed;
- H. Plans for coordinating the services with other agencies, if applicable;
- I. The discharge plan of the member;

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**97.07 POLICIES AND PROCEDURES (cont.)**

- J. Written progress notes as appropriate for each type of facility or PNMI, the minimum for each being a monthly note, which shall identify the services provided and progress toward achievement of goals.

**97.07-5 Program Integrity**

See Program Integrity (formerly Surveillance and Utilization Review) in the MBM Chapter I.

**97.07-6 Review of the Individual Service Plan**

A review of the individual service plan shall be conducted by the appropriate case review team and/or professional of the following facilities in accordance with the following:

- A. for substance abuse treatment facilities, the rules and regulations cited in Section 97.01-1(B);
- B. for child care institutions, the rules and regulations cited in Section 97.01-1(D); and
- C. for community residences for persons with mental illness, the rules and regulations cited in Section 97.01-1(E);  
  
Reviews for community residences for persons with mental illness must be made at least every ninety (90) days;
- D. for medical and remedial services facilities, the regulations cited in Section 97.01-1(C); and
- E. for non-case mixed medical and remedial facilities, the rules cited in Section 97.01-1(F) and the Chapter III, Principles of Reimbursement for Non-Case Mixed Medical and Remedial Facilities.
- F. for ITRT facilities, the rules cited in Section 97.01-1(F); and the Chapter III, Appendix D, Principles of Reimbursement for Child Care Facilities.

**97.07-7 Discharge Summary**

A discharge summary shall summarize the entire case in relationship to the plan of care.

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97.07    **POLICIES AND PROCEDURES (cont.)**

97.07-8    Time Studies

- A.    The Department requires time studies for educational staff performing duties as described in Section 97.06 to determine if a percentage of the time can be applied to direct service staff and is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400. The percentage of time determined in the time study that is applicable to academic services listed in MBM Chapter I, Section 1.06-4, Non-Covered and Non-Reimbursable Services will not be allowable time (and the costs related to that time) under Chapter III, Section 2400.
- B.    The Department requires time studies of direct time for staff who perform both covered direct services and other non-covered services for facilities covered under Appendices B, D, and E. The percentage of time determined from the time study spent in duties as described in Section 97.04 is an allowable cost under Chapter III, Principles of Reimbursement for Private Non-Medical Institutions, Section 2400.
- C.    Facilities must complete time studies in accordance with procedures prescribed by the Office of MaineCare Services.

97.07-9    Continuing Stay Requirements

Members must continue to meet the eligibility criteria set forth in each Section above for provider reimbursement in the PNMI setting.

97.08    **GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES**

Requirements identified in this Section shall be the responsibility of direct care staff. Direct care services include supervisory and training activities necessary to accomplish the provisions described in this Section. It also includes personal supervision or being aware of members' general whereabouts, observing or monitoring members to ensure their health and safety, assisting with or reminding members to carry out activities of daily living, and assisting members in adjusting to the facility and community.

97.08-1    Substance Abuse Treatment PNMI's – Medical and Clinical Requirements

A.    Medical and Clinical Responsibility

Clinical responsibility for implementation of each member's overall specific treatment plan shall rest with a treatment team, which shall be chosen from the qualified professional staff as defined in Section 2400 of the pertinent Chapter III, Principles of Reimbursement.

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All services must be provided pursuant to a written service plan based upon an individual assessment made in accordance with the Regulations for Licensing/Certifying Substance Abuse Treatment Programs in the State of Maine.

Service plans must be reviewed and signed by a physician, psychiatrist, psychologist, social worker, licensed clinical professional counselor, registered nurse or licensed alcohol and drug counselor as defined in Chapter II, Section 97.07-2.

Such qualified professional staff shall be responsible for the provision of direct services to members, and for direct supervision of all other staff in the implementation of the service plan through the various elements of the comprehensive treatment described in this Section. The qualified professional staff shall ensure that a full range of formal treatment services is provided to each member in conjunction with the structured set of activities routinely provided by the PNMI and in accordance with the individual member's needs. The range of formal treatment services provided to members by the PNMI shall aid the member, through non hospital based detoxification, type I residential rehabilitation, type II residential rehabilitation, halfway house services, extended care, adolescent residential rehabilitation, or personal care substance abuse services (shelter based), toward the primary goal of recovery for the chemically dependent person.

PNMI staff shall assess members for unmet mental health needs, and complement the substance abuse plan of care with appropriate referrals for mental health care.\_

**B. Personal Care Services**

PNMIs approved and funded by Adult Mental Health Services in licensed facilities must also provide necessary personal care services for the promotion of ongoing treatment and recovery. MaineCare does not cover personal care services provided by a family member.

Personal care services shall be prescribed by a physician, provided by qualified staff, and will occur in the substance abuse treatment PNMI where the member receiving services resides.

Personal care services shall consist of, but are not limited to, the following:

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- Assistance or supervision of activities of daily living that include bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety within the substance abuse treatment PNMI;
- Supervision of or assistance with administration of physician ordered medication;
- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member while on the premises to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member to carry out activities of daily living, and assisting the member in adjusting to the group living facility;
- Arranging transportation and making phone calls for medical or treatment appointments as recommended by medical providers, or as indicated in the member's plan of care;
- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate;
- Arranging or providing motivational, diversionary, and behavioral activities that focus on social interaction to reduce isolation or withdrawal and to enhance communication and social skills necessary for ongoing treatment and recovery, as described in the member's plan of care;
- Monitoring and supervising member's participation in the treatment; and
- Psychosocial treatment including assisting members to adjust to the substance abuse treatment PNMI, to live as independently as possible, to cope with personal problems during periods of stress, to accept and adjust to their personal life situations, to accept and cope with their chemical addictions and to decrease unhealthy behaviors leading to possible relapse into active addiction, in addition to providing services and a supportive environment which promotes feelings of safety and freedom from danger, fear or anxiety.

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**C. Non Hospital based Detoxification**

MaineCare limits non hospital based detoxification services to seven (7) days for each admission episode, with no limit on the number of admissions or covered days on an annual basis. The facility may provide detoxification services for a longer period if medical necessity is substantiated and ordered by the medical director, and documented in the member's clinical file by the facility's designated medical staff.

Detoxification services provide immediate diagnosis and care to members having acute physical problems related to substance abuse. Providers of detoxification services shall make and maintain arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI.

Each member shall receive a complete physical examination by a physician within forty-eight (48) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation and diagnosis upon intake. Designated areas suitable (1) for the provision of general medical services, and (2) to control and administer drugs prescribed by the PNMI's legally qualified staff, shall be maintained by the PNMI so as to assure the appropriate treatment of physical illness and maintenance of good general health among members. The member shall receive continuing medical supervision under the direction of a physician while in the PNMI that shall be documented in the member's case record. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals and physical examinations.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to good health and enabling the member to sustain a substance free life style. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24) hour, on-premises medical coverage by a registered nurse or licensed practical nurse who is experienced in the



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disease process of chemical dependency. Physician back up and on-call staff shall be provided to deal with medical emergencies.

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D. Residential Rehabilitation Type I

MaineCare limits residential rehabilitation type I to thirty (30) days for any single admission, with a limit of two (2) admissions and thirty (30) covered days on an annual basis per member. These limits allow some clinical flexibility should additional treatment be required or should a member drop out very early in treatment and are admitted at a later date.

Any continuous stay in excess of twenty-eight (28) days requires documented need in the member's treatment plan.

Residential rehabilitation shall provide scheduled therapeutic treatment consisting of diagnostic and counseling services designed to enable the member to develop a substance free life style.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Admissions resulting from a direct physician referral by telephone may be sufficient to meet this requirement so long as the orders are taken by an RN or an LPN who has been trained to take telephone orders. The referring physician shall sign these orders within forty-eight (48) hours.

PNMIs shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI shall be made and maintained by the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to good health and the maintenance of a substance free life style. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling at a minimum of ten (10) hours per week.

The PNMI shall maintain a medical staffing pattern, which enables it to meet the physical care requirements delineated above. The PNMI shall provide for twenty-four (24)-hour staff coverage. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

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The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

**E. Adolescent Residential Rehabilitation Services**

Adolescent residential rehabilitation PNMIs provide the opportunity for recovery through modalities, which emphasize personal growth through family and group support and interaction. The PNMI's qualified staff shall teach attitudes, skills, and habits, conducive to facilitating the member's transition back to the family and community. Adolescent residential rehabilitation PNMIs are designed to last at least three (3) months and are limited to twelve (12) months per single admission.

MaineCare does not cover in-house, accredited, individualized schooling, weekly vocational exploration groups, and structured recreational activities.

Services must include but are not limited to:

- Medical evaluation;
- Physical examination within seventy-two (72) hours following admission or no more than thirty (30) days prior to admission, and laboratory examinations as appropriate and as soon as practicable after the member's admission;
- Individual and group counseling at a minimum of ten (10) hours per week for each member;
- Arrangements for needed health care services; and
- Planning for and referral to further treatment.

The PNMI shall document that all persons providing services are legally qualified through licensure, certification, and/or registration as required to provide the service. PNMIs shall have qualified (as described in Section 2400 of these principles) staff coverage twenty-four (24) hours a day, including weekend coverage and shall include weekly clinical supervision to the staff to ensure the well-being of the members and to provide for the growth and development of the staff.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section. For the purposes of this Section, physician consultant services are not considered subcontracting.

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**F. Halfway House Services-**

MaineCare limits halfway house services to a single admission of one hundred eighty (180) covered days on an annual basis per member. Any stay in excess of one hundred eighty (180) days requires documented need in the member's service plan.

A halfway house shall provide scheduled therapeutic and rehabilitative treatment consisting of transitional services designed to enable the member to sustain a substance free life style in an unsupervised community living situation.

Counseling staff of the PNMI shall perform an assessment of the member's medical and social/psychological needs, as required by the Office of Substance Abuse, within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days. Such assessment may be completed prior to admission by the substance abuse treatment facility referring the member. This assessment may additionally include, but not be limited to an examination for contagious or infectious disease, determination of the status of chronic physical disease and examination of nutritional deficiencies. Arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the PNMI shall be made and maintained by the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

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**G. Extended Care Services**

MaineCare limits extended care services to a single admission of two hundred seventy (270) covered days on an annual basis per member. Any stay in excess of two hundred seventy (270) days requires documented need in the member's treatment plan.

Extended care services shall provide scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment.

Each member shall receive a complete physical examination by a physician within seventy-two (72) hours of admission and the results shall be entered in the member's record. Physical examinations performed more than thirty (30) days before admission are not acceptable. If the member's admission was based on the results of a physical examination performed thirty (30) or fewer days before admission, the PNMI's physician must approve the prior examination or re-examine the member within forty-eight (48) hours after admission.

PNMIs shall provide medical evaluation upon intake and laboratory examinations as deemed appropriate by the physician as soon as practicable after admission. The PNMI shall establish procedures for the prompt detection and treatment of physical health problems through surveillance, periodic appraisals, and physical examinations. The PNMI is responsible for referring the member to external clinicians and facilities for specialized services beyond the capability of the PNMI.

The PNMI's qualified staff shall teach attitudes, skills, and habits conducive to facilitating the member's transition back to the community. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling.

The PNMI shall have a written agreement with an ambulance service to assure twenty-four (24)-hour access to transportation to emergency medical care facilities for members requiring such transport. Physician back-up and on-call staff shall be provided to deal with medical emergencies.

The PNMI shall not subcontract any of its obligations and rights pertaining to medical services described in this Section, with the exception of physician consultant services.

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**H. Residential Rehabilitation Type II**

Residential Rehabilitation Type II will provide a structured therapeutic environment for members who are on a waiting list for treatment, or who have either completed detoxification treatment, or are otherwise not in need of detoxification services. The primary objectives of Residential Rehabilitation Type II are; to stabilize the substance abuser in order to provide continuity of treatment, to enable the member to develop an appropriate supportive environment, to remain substance free and to develop linkages with community services.

The term of residency shall not exceed forty-five (45) days. The PNMI shall provide a daily structured sequence of individual and/or group counseling for the treatment of substance abuse provided by qualified staff members (listed in Section 2400 of the pertinent Chapter III, Principles). MaineCare does not cover other educational and vocational counseling required by the Office of Substance Abuse Regulations for Extended Care Shelters.

Services provided will depend upon the therapeutic needs of individual members and must include but are not limited to:

- Evaluation of the member's medical and psychosocial needs;
- A medical examination by a physician within five (5) days of admission unless the member can show evidence of such examination within the last thirty (30) days;
- Opportunities for learning basic living skills, such as personal hygiene skills, knowledge of proper diet and meal preparation, constructive use of leisure time, money management and interpersonal relationship skills, all of which are considered non-covered services by MaineCare;
- Clinical services, including individual and group counseling; and
- Opportunity for family involvement.

The PNMI shall have twenty-four (24)-hour coverage by on-site trained staff (as required by Adult Mental Health Services) and include weekend coverage.

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Each PNMI shall provide at least one (1) hour per week of professional consultation to the clinical staff to ensure the well being of the members and to provide for the growth and development of the staff. This consultation may be either on a group or individual basis.

The PNMI shall assure the availability of a transportation support system twenty-four (24)-hours a day, and shall maintain a written agreement for the provision of transportation between the facility and emergency care facilities.

**97.08-2 Child Care Facilities**

**A. General Description**

Responsibility for implementation of each member's individual service plan shall rest with a licensed or certified clinical personnel or staff person operating within the scope of his/her license or certification under Maine law. Such clinical personnel or staff is responsible for the provision of direct services and for documented supervision of other qualified staff involved in implementing the service plan. Supervisory arrangements must be made in accordance with licensing and certification regulations. The health professional may be employed by the facility or engaged through a consultant contract or agreement.

PNMIs must provide all services pursuant to a written service plan based on an individualized assessment of the member made in accordance with the Rules for the Licensure of Residential Child Care Facilities or the Rules for Licensure of Child Placing Agencies, whichever is applicable.

Service plans must be developed, approved and signed in accordance with the Rules for Licensure of Residential Child Care Facilities or Rules for Licensure of Child Placing Agencies. The plan shall specify the treatment and rehabilitative services to be provided. The plan shall be reviewed and documented according to the applicable licensing requirements

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Providers must maintain records in accordance with Chapter I and Chapter II, Sections 97.07-4, and 5 of the MaineCare Benefits Manual. Discharge summaries shall be consistent with the Rules for the Licensure of Residential Child Care Facilities and Rules for Licensure of Child Placing Agencies.

Rehabilitative services are designed to improve member's instrumental functioning in daily living, emotional and physical capability in areas of daily living, community integration and interpersonal functioning. These services include, but are not limited to:

- Group therapy aimed at improving a member's emotional integration, self-awareness, and environment;
- Emotional development skills training aimed at promoting behaviors that affect a member's relations with other people and the member's attitudes, interest, values, and emotional expression;
- Daily living skills training, aimed at addressing member dysfunction in areas necessary to maintain independent living;
- Interpersonal skills training, such as structured learning therapy, which are aimed at addressing member dysfunction in areas of social appropriateness and social integration;
- Community skill training, such as modeling therapy that is aimed at ameliorating member dysfunction in the awareness and appropriate use of community resources; and
- Collateral contacts, which mean a face-to-face contact on behalf of the member by clinical personnel or qualified staff to seek information, or discuss the member's case with other professionals, caregivers, or others included in the treatment plan in order to achieve continuity; of care, coordination of services, and the most appropriate mix of services for the member. Discussions or meetings with staff of the PNMI provider on behalf of the same member are not considered to be collateral contacts.

**B. Physical Care**

The population served by child-care facilities tends to manifest a wide variety of physical problems in addition to those mental health or behavioral disorders that are the primary presenting problems. For this reason, it is imperative that the provider provides physical care for members that is integral rather than adjunctive. In this sense, the provider shall assure that physical care exists that meets the primary care needs of

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members. The provider shall coordinate and collaborate with other physical health care providers to assure the appropriate treatment of physical illness and the maintenance of good general health among members. The provider shall also maintain arrangements with external clinicians and facilities for the provision of specialized medical, surgical, and dental services to members.

**97.08-3 Community Residences for Persons with Mental Illness**

Direct member services performed by clinical personnel refers to mental health treatment, substance abuse treatment, rehabilitative services and/or personal care services performed as deemed medically necessary and described in an authorized plan of care with the member present and participating. These services are provided within the scope of their licensure or certification by physicians, psychiatrists, psychologists, social workers, psychiatric nurses, psychological examiners, occupational therapists, other qualified mental health staff, personal care service staff, licensed substance abuse staff, licensed clinical professional counselors, licensed professional counselors or other qualified alcohol and drug treatment staff as defined in Chapter II, Section 97.07-2.

Mental health treatment and rehabilitative services refer to direct member services provided for reduction of a mental illness and restoration of a member to his/her best possible functional level. These services focus on the establishing or regaining of functional skills; the increase of self-understanding, crisis prevention and self management; socialization and leisure skill development; the development and enhancement of social roles within the context of natural supports, the consumer's community, and others within the residential treatment facility; and other activities connected with the rehabilitation goals and objectives identified in the plan of care.

These services are deemed medically necessary and described in an authorized plan of care and are provided with the member present and participating. The individualized rehabilitation plan shall include sequential steps developed with the consumer. Treatment planning will include, when possible, community staff providing services outside the facility as well as residential treatment facility staff. Planning will also include any other individuals that the member chooses. The plan will reflect individualized goals and objectives identifying the tailored services to be provided. Services provided are based on a well defined, time-limited plan that focuses on the member's particular strengths, needs, and choices and which is developed through a regularly scheduled, individualized planning process on a quarterly basis. One of the key elements reflected in the services provided by the facility is that of the expectation of growth and recovery. Mental health treatment and rehabilitative services are provided by physicians, psychiatrists, psychologists, social workers, licensed clinical professional



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counselors, licensed professional counselors, certified interpreters, psychiatric nurses, psychological examiners, occupational therapists, and other qualified mental health staff, as defined in Chapter II, Section 97.07-2, operating within their competence in accordance with state law.

MaineCare does not cover personal care services provided by a family member. Personal care services must be prescribed by a physician, are provided by other qualified mental health staff, in accordance with their respective plans of care, as defined in Section 97.07-2 (E) and include, but are not limited to, the following:

- Assistance or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the member's health and safety;
- Supervision of or assistance with administration of physician ordered medication;
- Personal supervision or being aware of the member's general whereabouts, observing or monitoring the member to ensure their health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community;
- Arranging transportation and making phone calls for appointments as recommended by medical providers or as indicated in the member's plan of care; and
- Observing and monitoring member's behavior and reporting changes in the member's normal appearance, behavior, or state of health to medical providers or supervisory personnel as appropriate.

Integrated treatment services for persons with coexisting disorders (chronic mental illness and substance abuse) shall include mental health and substance abuse rehabilitative services. These services assist members in confronting their addiction history (alcohol and drug abuse) and develop motivation for long-term compliance and plans for ongoing recovery and treatment. Such rehabilitation services include individual counseling, family therapy, group therapy, and other services necessary to enhance a member's successful transition to housing and services in the community and promote the ability to function as independently as possible in the community.

Integrated treatment services shall also include independent living skills and social skills services, necessary to promote ongoing recovery and treatment. Specific treatment goals and objectives of such services shall be documented in each member's individual service plan.

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MaineCare does not reimburse for services that are primarily academic, vocational, socialization or recreational in nature, as described in Chapter I of the MaineCare Benefits Manual. MaineCare does not reimburse self-help supportive meetings.

**A. Description of the Facility's Clinical Services**

Clinical responsibility for implementation of each member's individual service plan shall rest with a licensed or certified mental health professional operating within the scope of his/her license or certification under Maine law. Such mental health professional shall be responsible for the provision of direct services and for documented supervision of other qualified mental health staff involved in implementing the service plan. The Department, in accordance with its licensing and certification regulations, must approve supervisory arrangements. The mental health professional may be employed by the facility or engaged through a consultant contract or agreement.

Within thirty (30) days of the entry of the member in the facility, all services must be provided pursuant to a written service plan based on an individualized assessment of the member made by a psychiatrist, psychologist, physician, licensed clinical social worker, psychiatric nurse, licensed master social worker conditional I, licensed master social worker conditional II, licensed clinical professional counselor or licensed clinical professional counselor conditional. The plan shall specify the treatment and rehabilitative services to be provided at the facility site. The plan shall be reviewed and documented every ninety (90) days.

Records must be maintained and reviewed in accordance with Sections 97.07-4, 5, and 7.

Only services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services are reimbursable. It is recognized that many elements of a comprehensive plan of services to mentally ill members are not reimbursable by MaineCare. Services reimbursable under Section 97, Chapter III may complement, but must not duplicate, services provided outside of the facility, regardless of the actual provider of services. Each member's comprehensive individual service plan shall assure the most appropriate non-duplicative mix of services.

**B. Personal care services**

PNMIs approved and funded by Adult Mental Health Services in licensed facilities must also provide personal care services necessary for the promotion of ongoing treatment and recovery.

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**97.08 GENERAL DESCRIPTION OF THE FACILITY'S CLINICAL SERVICES (cont.)**

**97.08-4 Medical and Remedial Facilities**

Medical and remedial facilities, whether they are case-mix reimbursed or non-case mix reimbursed facilities, include services provided at the facility for the diagnosis, assessment, treatment, rehabilitation, or provision of personal care services. These services must be provided within the scope of licensure or certification by staff as defined in Section 97.07-2.

MaineCare does not cover personal care services provided by a family member. A physician must prescribe personal care services. Other qualified personal care staff must provide services in accordance with respective plans of care, which include, but are not limited to, the following:

- Provision of personal care and nursing services;
- Assistance with or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene activities, grooming, and the performance of incidental household tasks such as food preparation, laundry, and housekeeping essential to the activities of daily living and to the maintenance of the member's health and safety;
- Supervision of or assistance with the administration of physician ordered medication;
- Personally supervising or being aware of the member's general whereabouts, observing or monitoring the member to ensure his or her health and safety, reminding the member to carry out activities of daily living, and assisting the member in adjusting to the facility and the community; and
- Arranging transportation for appointments as recommended by medical providers or as indicated in the member's plan of care.

**97.08-5 Intensive Temporary Residential Treatment Services (ITRT)**

Providers must include at least four family meetings per month as part of the treatment process unless documentation in the treatment plan indicates that such meetings are counterproductive to the child's progress. Each child must have an initial plan developed within the first seventy-two (72) hours of admission, and a comprehensive treatment plan developed within twenty (20) working days after admission.

Providers must meet all of the following requirements:

- A. The comprehensive treatment plan shall include, but not be limited to:

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1. A comprehensive assessment including all of the following dimensions:
  - a. Psychiatric, including a diagnostic formulation, to include Axis I – V and specific DSM-IV criteria met;
  - b. Psychological;
  - c. History and physical;
  - d. Neurological, if indicated;
  - e. Educational;
  - f. Recent psychological assessment (including I.Q. and Learning Disability (LD) assessment);
  - g. Medication, including target symptoms and risk and benefit statement;
  - h. Any other assessment warranted by the child's condition and/or illness.
2. Description of the child's strengths and service needs;
  - a. A description of the short-term and long-term treatment goals, focusing on specific benchmarks for the child to return home. These must be specific, measurable, achievable, realistic, and time limited;
  - b. The rationale for utilizing a particular method or modality of treatment;
  - c. The family's responsibilities (i.e. visitation, family therapy sessions, contacting school, etc.);
  - d) A specification of treatment goals in the service plan describing responsibility for staff, child, and parent/guardian involvement to attain treatment goals;
  - e) An assessment at each clinical review, of whether the child may be safely discharged, to include specific barriers preventing discharge; and
3. Documentation of current discharge planning.

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- B. Progress notes must be entered into the record at least weekly, at a minimum addressing specific goals indicated in the individual treatment plan. These notes must include, but are not limited to the following:
  - a) A description of the services rendered to the child since the last note was entered, including a description of the specific interventions used;
  - b) A description of the child's response to these interventions;
  - c) The child's progress toward the identified goals, as indicated by objective measures whenever possible;
  - d) A description of the service rendered to the family since the last note was entered, including specific interventions used;
  - e) A description of the family's response to these interventions; and
  - f) The family's progress toward these goals, as indicated by objective measures whenever possible.
- C. Physician notes, when appropriate, must be kept for:
  - 1) General progress, with notes entered and updated in the record; and changes or additions of medications: Notes must document:
    - a. Reasons for using the specified medication;
    - b. Risks and benefits for using the specified medication, including possible medication interactions;
    - c. Documentation that informed consent including indication, risk benefit has been received prior to administration; and
    - d. Documentation of therapeutic response to any new or changed medications, including review of side effects.

**97.09 REIMBURSEMENT**

For each MaineCare provider enrolled as a participating Private Non-Medical Institution, the Department will determine an interim per diem rate, as determined under Chapter III, Section 97, Principles of Reimbursement for Private Non-Medical Institution Services and the applicable Appendix.

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97.09 **REIMBURSEMENT** (cont)

Providers are required to obtain separate MaineCare provider number(s) for each PNMI provider type as described in Section 97.01-1. Upon completion of the provider's fiscal year, the providers shall submit to the Department, a cost report for each PNMI that has been assigned a provider number(s) in accordance with Chapter III of the Principles of Reimbursement.

Agencies that obtain public funds from another source to use as either a portion or as the entire State share of the PNMI rate must complete a Rider A as part of their Provider/Supplier Agreement to certify the State share of MaineCare funding. If certified public funds support only a portion of the PNMI rate, the full rate must be paid to the provider, with an adjustment made at settlement to reimburse the Department the amount certified in Rider A. This amount will be reported to the Department using Chapter III, Section 97 rules for the submission of cost reports.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

97.10 **BILLING INFORMATION**

Providers must bill in accordance with the Department's billing Instructions for the UB-04 Claim Form. Billing instructions are available at: <http://www.maine.gov/bms/provider.htm>.

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GENERAL PROVISIONS

1000 PURPOSE

The purpose of these regulations is to define which items of expense will be taken into account and which will be excluded in the calculation of reasonable costs for Private Non-Medical Institutions. These Principles of Reimbursement for Private Non-Medical Institutions identify which costs are reimbursed under Chapter II, Section 97 - Private Non-Medical Institution (herein after, PNMI) Services of the MaineCare Benefits Manual. The Department will consider allowable costs identified by these Principles for reimbursement of services in a residential child care facility, substance abuse treatment facility, and community residences for persons with mental illness (for those facilities covered under Appendices B, D, and E) on the first day of the provider's fiscal year beginning on or after July 1, 2001. The Department will consider allowable costs identified by these Principles of Reimbursement for Private Non-Medical Institution medical and remedial facility services (under Appendices C and F) rendered on or after July 1, 2001. Prior to July 1, 2001, PNMI services rendered in a medical and remedial facility and non-case mixed medical and remedial facility shall follow the applicable appendix in effect prior to July 1, 2001, and the Principles of Reimbursement for Residential Care Facilities- Room and Board Costs.

1100 SCOPE/AUTHORITY

These Principles define scope and authority within the specific Appendix applicable to that type of Private Non-Medical Institution. These Principles define Department and member/resident in Section 10000 of this policy. These Principles define facility in each specific Appendix.

1300 ADULT FAMILY CARE HOMES

1300.1 The Department does not use these PNMI Principles in the determination of the reimbursable amount paid to Adult Family Care Homes.

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1400 REQUIREMENTS FOR MAINECARE REIMBURSEMENT

1400.1 In order to be reimbursed, all PNMI's identified as residential child care, substance abuse treatment, community residences for persons with mental illness, and Appendix F scattered site PNMI's for people for mental retardation must be licensed as applicable, in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment Services, or Rules for the Licensure of Residential Child Care Facilities/Rights of Recipients of Mental Health Services Who are Children in Need of Treatment. In order to be reimbursed, medical and remedial service PNMI's and non-case mixed must be licensed by the Division of Licensing and Certification in the Department of Health and Human Services (See 10-149 C.M.R., Ch. 113), with the exception of Appendix F scattered site PNMI's for persons with mental retardation, which may be licensed as either a residential care facility or as a mental health provider in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment services.

1400.2 All PNMI's must obtain licensure and a signed Provider/Supplier Enrollment Agreement with the Department of Health and Human Services, Office of MaineCare Services (OMS). Providers must submit a copy of the license accompanying the Provider/Supplier Enrollment Agreement to the Department.

1400.3 Types of PNMI's considered for MaineCare reimbursement, subject to the availability of funds, include:

1400.31 Facilities providing Private Non-Medical Institution services to members with significant mental or physical disability requiring structured, individualized habilitative or rehabilitative in-home programming as outlined in the provider agreement with the PNMI.

1400.32 Facilities with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of the applicable appendix stated below.

Appendix B Substance Abuse Treatment Facilities

Appendix D Child Care Facilities

Appendix F Non-Case Mixed Medical and Remedial PNMI's

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1400 REQUIREMENTS FOR PARTICIPATION IN MAINECARE (cont.)

- Eff 2/13/11
- 1400.4 Except for Child Care Facilities covered under Appendix D, and Substance Abuse Treatment Facilities covered under Appendix B, the Department will reimburse PNMI's for services provided to eligible members based on an interim rate that the Department establishes and determines as reasonable and adequate to meet the costs that are incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Appendix B and Appendix D standard rates are not interim and are not subject to cost settlement guidelines detailed in this Chapter.
- 1400.5 The Department requires cost reimbursed facilities to submit annual cost reports as stated in Section 3300.
- 1400.6 The Department will respond in writing to written requests for interpretation of these Principles. Providers should direct written requests to the Director, Office of MaineCare Services.
- 1400.7 The Department reserves the right to take legal action against, and/or terminate the provider agreement if a facility fails to comply with these Principles, or submits, or causes to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

1500 RESPONSIBILITIES OF OWNERS OR OPERATORS

The owners or operators of a Private Non-Medical Institution must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner, nor a duly authorized representative may in any way relieve the owner or operator of a PNMI from full responsibility for compliance with the requirements and standards of the Department or Federal requirements and standards.

1600 DUTIES OF THE OWNER OR OPERATOR

In order to qualify for MaineCare reimbursement the owner or operator of a PNMI, or a duly authorized representative must:

- 1600.1 Comply with the provisions of Chapter I; and Chapters II, III, and the applicable Appendix of Section 97 of the MaineCare Benefits Manual.
- 1600.2 Submit master file documents and cost reports in accordance with the provisions of Sections 3100 and 3300 of these Principles. Child Care providers under Appendix D must also submit these documents and cost reports, which the Department utilizes in setting appropriate reimbursement rates.

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1600 DUTIES OF THE OWNER OR OPERATOR (cont.)

1600.3 Maintain adequate financial and statistical records and make them available for inspection by an authorized representative of the Department, State, or the Federal government upon request.

1600.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.

1600.5 Assure that the construction of buildings and the maintenance and operation of premises and residential services comply with all applicable health and safety standards.

1600.6 Submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 7000 of these Principles.

1700 COVERED SERVICES

See applicable section of Chapter II, Section 97, Private Non-Medical Institution Services.

1900 TERMINATION UNDER TITLE XIX

Termination of participation in Title XIX will result in the provider being terminated simultaneously from financial participation under PNMI cost reimbursement. Alternatively, termination of participation in cost reimbursement will result in the provider being terminated simultaneously from participation in Title XIX. Conditions that may result in termination of participation in MaineCare are listed in Chapter I of the MaineCare Benefits Manual. These conditions may result in termination of the provider contract to provide PNMI services:

1900.1 The Federal Government fails to provide agreed upon funds; or

1900.2 The State share of funds is unavailable; or

1900.3 The life, health, or safety of persons served is endangered, in the opinion of the Department; or

1900.4 The provider fails to submit fiscal or program reports on the prescribed dates; or

1900.5 Either the Department or the provider receives a written notice from the other for any reason stating that termination will occur in no later than 30 days; or

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1900 TERMINATION UNDER TITLE XIX (cont.)

1900.6 The provider fails to meet the applicable licensing regulations after a reasonable time for correction, or if the provider fails to deliver services in accordance with the plan of care; or

1900.7 The license to operate is revoked by Department or court action, or if the facility's owner or its administrator is convicted of any crime related to operation of the facility; or

1900.8 The same services can be provided at a lower rate on a fee-for-service basis or if the per diem rate is greater than the rates that third party payers are paying for comparable services under comparable circumstances.

2000 ACCOUNTING REQUIREMENTS

2000.1 All financial and statistical reports must be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless specific variations are required by these principles.

2000.2 The provider must establish and maintain a financial management system that assures adequate internal control and accuracy of financial data, the safeguarding of assets and operational efficiency.

2000.3 The provider must report on an accrual basis, unless it is a State or municipal institution that operates on a cash basis, unless the Department and the Department providing the State share of MaineCare reimbursement approves exceptional circumstances. The provider whose records are not maintained on an accrual basis must develop accrual data for reports on the basis of an analysis of the available documentation. The provider must retain all such documentation for audit purposes.

2000.4 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. The provider may submit a rate schedule to the Department to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the Private Non-Medical Institution.

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2300 COST RELATED TO RESIDENT CARE (Excluding Appendix B and D Facilities)  
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2300.1 In order to be allowable, compensation must be reasonable and for services that are necessary and related to PNMI services. The services must actually be performed and incurred by the PNMI or its contractors. Providers must report all compensation to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

Providers may not claim reimbursement for personal expenses unrelated to member care. Bonuses that are part of a written policy of the provider and which require some measurable and attainable employee job performance expectations are allowable. Bonuses based solely on the availability of any anticipated savings are not allowable.

2300.2 Costs incurred for PNMI services that are rendered in common to MaineCare residents as well as to non-MaineCare residents, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff.

See applicable Appendix for each type of PNMI for the list of approved direct service staff:

Appendix B	Substance Abuse Treatment Facilities
Appendix C	Medical and Remedial Service Facilities
Appendix D	Child Care Facilities
Appendix E	Community Residences for Persons with Mental Illness
Appendix F	Non-Case Mixed Medical and Remedial Facilities

2400.2 Allowable costs shall also include the following taxes and benefits applicable to direct service staff as defined in the applicable Appendix:

Payroll taxes/unemployment payroll taxes  
Health insurance  
Dental insurance  
Employer term life/disability insurance  
Qualified retirement contributions  
Worker's Compensation insurance

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2400 ALLOWABILITY OF COST (cont.)

2400.3 The Department will approve the direct care staffing.

2400.31 The Department will determine the reasonableness of costs based on the budget submitted prior to the beginning of the provider's fiscal year, subject to final approval by the Office of MaineCare Services. The total amount approved in the budget will serve as a cap for reimbursement.

2400.32 A Rate Letter will inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Section 2400, Chapter III, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the Industry Price and Average Case Mix Index.

2400.4 Allowable costs may also include contract fees, which are fees paid in lieu of salary, paid for use of foreign exchange fellows, such as those participating in the ILEX international professional exchange program for social workers, in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department, and must meet all staff qualifications. The Department will reimburse the provider for the contract fee, based on a calculation of hours worked by the foreign exchange fellow, at the salary, wages and taxes and benefits that would be allowable under these regulations for a comparable direct service staff working those hours. The Department will only reimburse up to the allowed contract fee amount, and will not reimburse any wages and benefits to the foreign exchange fellow other than reimbursing the allowable contract fee amount.

2410 State-Mandated Service Tax: Effective July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services, as defined in 36 M.R.S.A. § 2552 (1)(G).

2450 Program Allowance: See the applicable Appendix for the allowable program allowance.

The maximum reimbursement amount allowed, including the program allowance, will not be greater than the total costs of the program.

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2400 ALLOWABILITY OF COST (cont.)

2470 Certifying Other Qualified Staff (With exception for Appendix C and F facilities) Training and experience requirements of other qualified staff may vary by definition. However, in all cases, other qualified staff including exchange fellows must be certified or approved by a specified State agency, or its designee, as meeting these requirements. (The specified State agency, or its designee, would be the agency approving the staff for the facility.) These certifications/approvals must be on file. The approval must be in writing and dated at the time the approval is made. This approval process must not be delegated to a provider. The PNMI provider may certify to the approving agency that employees have or will have the requisite training. However, the approving agency must provide the written approvals for the provider to maintain on file. MaineCare payments made for individuals who have not been approved provisionally or fully certified by the State agency, or its designee, are subject to recoupment.

2480 If these Principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used, reference will be made first to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

2500 NON-ALLOWABLE COSTS

An unallowable cost includes all costs not included in Section 2400.

2600 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

2700 RECORD KEEPING AND RETENTION OF RECORDS

2700.1 Providers must make all financial and member records available to representatives of the State of Maine, Department of Health and Human Services or the U.S. Department of Health and Human Services, or the Maine Attorney General's Office, as required by Section 2700.3.

The Department will give providers a three-day notice when requesting fiscal records.

2700.2 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report.



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2700 RECORD KEEPING AND RETENTION OF RECORDS (cont.)

- 2700.3 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, Federal and State income tax information, asset acquisition, lease, sale, or any other action, franchise or management arrangement, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities will extend to realty, management, and other entities for which any reimbursement is directly or indirectly claimed, whether or not they fall within the definition of related parties.
- 2700.4 The provider must maintain all such records for at least 5 years from the date of settlement of the final audit. The Division of Audit must keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit must retain all records that are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.
- 2700.5 When the Department determines that a provider is not maintaining records as outlined above for the determination of reasonable cost in the PNMI, the Department, upon determination of just cause, may impose the deficiency rate as described in Section 7000 of these Principles.

2900 BILLING PROCEDURES

- 2900.1 Substance abuse treatment facilities, child care facilities, and community residences for persons with mental illness will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.
- 2900.2 Medical and remedial service facilities will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.
- 2900.3 Claims cannot include dates of service that overlap the provider's fiscal years.

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3000 REIMBURSEMENT METHOD

3000.1 The Department will reimburse facilities for services provided to members based on a rate that the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility. The provider must provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

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3000.11 Except for Appendix B and Appendix D facilities, the Department will limit reimbursement to the approved amount in Section 2400. Appendix B and Appendix D facilities receive a standard rate not subject to Section 2400 adjustments for allowability of cost.

3000.2 Rate Setting Procedures

See applicable Appendix for type of Private Non-Medical Institution:

Appendix B Substance Abuse Treatment Facilities  
Appendix C Medical and Remedial Service Facilities Participating in Case Mix  
Appendix D Child Care Facilities  
Appendix E Community Residences for Persons with Mental Illness  
Appendix F Non-Case Mixed Medical and Remedial Facilities

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3000.3 Rate Adjustments For Facilities Under Appendix E and F

Facilities covered under Appendix E and F may request rate adjustments as necessary. The relevant Appendix details the process for such requests. The Department will not grant retroactive rate adjustments unless they are approved by the OMS and the Department under exceptional circumstances as determined by these two agencies.

3000.4 For out-of-state PNMI services provided by out-of-state providers, the Division of Financial Services will determine whether the rate paid to these providers will be either 1) based on the methodology set forth in this section, or 2) be the Medicaid rate of the state in which the PNMI services are provided.

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3100 FINANCIAL REPORTING

3100.1 Master File

When requested by the Department the provider must submit the following documents to the Office of MaineCare Services or its designee. Providers must update documents to reflect any changes. The Department will use the following documents to establish a master file for each facility in MaineCare:

- 3100.11 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
- 3100.12 Chart of accounts and procedures manual, including procurement standards;
- 3100.13 Plant layout;
- 3100.14 Terms of capital stock and bond issues;
- 3100.15 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing, and bonus agreements;
- 3100.16 Schedules for amortization of long-term debt and depreciation of plant assets;
- 3100.17 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
- 3100.18 Related party information on affiliations, and contractual arrangements;
- 3100.19 Tax returns of the Private Non-Medical Institution; and
- 3100.20 Any other documentation requested by the Department for purposes of establishing a rate.

If any of the items listed in Subsections 3100.11 through 3100.20 are not submitted in a timely fashion, the Department may impose the deficiency per diem rate described in Section 7000 of these Principles.

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3300 UNIFORM COST REPORTS

3300.1 The Department requires all PNMI's to submit cost reports. Cost reports, as prescribed herein, must be mailed to the State of Maine, Department of Health and Human Services, Division of Audit, and to the Division of Financial Services, Office of MaineCare Services, 11 State House Station, Augusta, ME, 04333-0011. Those out-of-state providers who are using another state's Medicaid rate or have two or fewer MaineCare residents must obtain prior authorization from the OMS Division of Financial Services, # 11 State House Station, Augusta, Maine 04333-0011 to be exempted from filing a cost report. The facility's financial statements will be the basis for completing the cost report. The cost reports must be based on the fiscal year of the facility. If the provider determines from its as filed cost report that it owes money to the Department, a check equal to 50% of the amount owed to the Department must accompany the cost report. If the Department does not receive a check with the cost report, the Department may elect to offset, pursuant to State and federal law, the current payments to the facility until the entire amount is collected from the provider.

3300.2 Forms/Electronic Media. The Department will supply annual cost report forms/electronic media for use by PNMI's in the State of Maine.

3300.3 Each PNMI in Maine must submit a completed annual cost report within five months of the end of each fiscal year on forms/media prescribed by the Division of Audit. If available, the PNMI will submit a copy of the cost report on a computer disk or electronically.

The inclusive dates of the reporting year are the 12-month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit an acceptable cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 7000.

3300.4 Certification by operator. Each provider must examine the cost report and supporting schedules prepared for submission to the Department and must certify that the report is a true, correct, and complete statement prepared from the books and records of the provider. The owner or administrator of the PNMI must certify the cost report. If someone other than the owner or administrator prepares the return, the preparer must also sign the report.

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3300 UNIFORM COST REPORTS (cont.)

3300.5 The provider must submit the Cost Report with required supporting documentation to the Division of Audit. Supporting documentation requirements are defined by the Division of Audit. Supporting documentation includes, at a minimum, financial statements and reconciliation of the financial statements to the cost report. All cost reports must bear original signatures.

Providers must also submit a copy of the cost report without supporting documentation to the Division of Financial Services at the Office of MaineCare Services.

3300.6 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

3300.7 The Division of Audit may reject any cost report filing that does not comply with these regulations. In such case, the report will be deemed not filed, until refiled and in compliance. A rejected cost report will subject the provider to the deficiency per diem as stated in Section 7000.

3300.8 Extension for filing of the cost report with the required supporting documentation beyond the prescribed deadline will only be granted under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).

3300.9 When a provider fails to file an acceptable cost report by the required date, the Department will send the provider a notice by certified mail, return receipt requested, advising the provider that all payments will be suspended until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward, but reimbursement for the suspension period will be at the deficiency rate as stated in Section 7000.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

See applicable PNMI Appendix for uniform desk review procedures.

3400.2 Calculation of the Final Settlement

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3400 SETTLEMENT OF COST REPORTS (cont.)

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See Applicable Appendix for calculation of the final settlement. Calculation of the final settlement is subject to reimbursement methods, limits, and reductions set forth in this Section. Appendix D facilities are not subject to cost settlement. Effective 11/15/10 Appendix B services will not be subject to cost settlement.

3500 ADJUSTMENTS TO AUDIT SETTLEMENTS (Except for Appendix D and B)

3500.1 Finalized cost report determinations and decisions may be reopened and corrected when the Division of Audit finds new and material evidence submitted by the provider or discovered by the Department or evidence of a clear and obvious material error.

3500.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision that is otherwise final. Such action may only be taken:

3500.21 At the request of either the Department or a provider, within the applicable time period set out in paragraph 3500.4; and,

3500.22 When the reopening may have a material effect (more than one percent) on the provider's MaineCare rate payments.

A correction is a revision (adjustment) in the Division of Audit's determination, otherwise final, that is made after a proper re-opening. The Division may make a correction, or require the provider to file an amended cost report.

3500.4 A re-opening of an audit may occur within three years from the date of notice containing the Division of Audit's determination, or the date of a decision by the Commissioner or a court. No time limit will apply in the event of fraud or misrepresentation.

3500.41 A cost report is settled if there is no request for reconsideration of the Division of Audit's findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

3500.42 No final audit will be reopened, or any hearing allowed concerning matters contained in any final audit if three years following the date of the final audit settlement have passed. This limitation does not apply in the event of fraud or misrepresentation.

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- Eff 3600 SETTLEMENTS OF OVERPAYMENTS OR UNDERPAYMENTS (Except for Appendix B  
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- 3600.1 Underpayments: If, at the time the audit is completed, the Department determines that it has underpaid a facility, the Department will pay the amount due and forward the result to the facility within thirty working days.
- 3600.2 Overpayments:
- 3600.21 If the Department has overpaid a provider, it will recover overpayments by offset, recoupment, or other methods allowed by law.
- 3600.22 The department may withhold payment on pending or future claims in an amount equal to the overpayment, pursuant to State and federal law. The amount may be withheld all at once or over a period of time established by the Department. Amounts are to be repaid within 90 days of the date the audit is finalized unless otherwise negotiated by the Department.
- 3600.23 If there are insufficient claims sent to the Department against which the Department can offset the amount of an overpayment, the Department will direct the provider to remit the payment in full. If repayment is not made, the Department may exercise any or all appropriate action against the provider and exercise all other civil remedies in order to recover the overpayments.

4000 PUBLIC HEARING

The State of Maine will provide for public hearings as described MBM, Chapter I.

5000 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, will not be construed as a waiver of future performance of the right. The obligation of the provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

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6000 POST AUDIT APPEAL PROCEDURES (Except for Appendix B and D)

6000.1 These provisions apply only to appeals after audit adjustment. See MBM, Chapter I for all other appeals procedures. A provider may administratively appeal an audit adjustment made by the Division of Audit.

6000.2 An administrative appeal will proceed in the following manner:

6000.21 Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.

6000.22 The Director or his/her designee will notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.

6000.23 To the extent the Department rules in favor of the provider, the audit report will be revised.

6000.24 To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

7000 DEFICIENCY PER DIEM RATE (Except for Appendix B and D)

In addition to the deficiency rate, civil and/or monetary sanctions may be applied by the State agency responsible for licensing the facility when a facility is found not to have provided the quality of service or level of care required. The Department will reimburse at 90% of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:



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2/13/11 7000 DEFICIENCY PER DIEM RATE (Except for Appendix B and D) (cont).

- 7000.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements;
- 7000.2 Food service does not meet the Federal Certification and State Licensing requirements;
- 7000.3 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than 30 days from written notification that such deficiencies exist;
- 7000.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;
- 7000.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit, and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiency per diem rate, suspension, withholding of, or recoupment of MaineCare reimbursement. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department.
- 7000.6 Failure to complete acceptable assessments, as defined in Appendix C.

A reduction in rate because of deficiencies will remain in effect until the deficiencies have been corrected, as defined in the applicable Appendix, or as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate will be made for the period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

8000 START UP COSTS APPLICABILITY

Prior to admitting residents, certain costs are incurred, which are referred to as start-up costs. No start-up costs can be allowed for the PNMI component.

## **10000 GENERAL DEFINITIONS**

“Accrual Basis of Accounting” means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

“Allowable Costs” are those operating costs remaining after the adjustments required by the Principles have been applied to the provider’s total operating costs reported in the annual cost reports.

“Cash Basis of Accounting” means revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

“Census/Days of Care”: For purposes of counting the number of patient days, the day of the patient's admission will be counted, but the day of discharge will not be counted.

“Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)” is the Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and federal Medicaid programs.

“Common Ownership” exists if an individual or individuals possess significant (10%) ownership or equity in the provider and the institution or organization serving the provider.

“Control” exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

“Cost Finding” are the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

“Days of Care” are total days of care provided whether or not payment is received and the number of any other days for which payment is received. (Note: Discharge days are included only if payment is received for these days.)

“Generally Accepted Accounting Principles (GAAP)” are those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

“Department” as used throughout these principles is the State of Maine Department of Health and Human Services.

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10000 GENERAL DEFINITIONS (cont.)

“Division of Audit” used throughout these Principles refers to the Department of Health and Human Services, Division of Audit.

“MaineCare Eligible Days” are the actual days of service for which payment was made by the Office of MaineCare Services through the claims process.

“Necessary and Proper Costs” are costs for services and items that are essential to provide appropriate resident care and resident activities at an efficient and economically operated facility. They are costs for services and items that are commonly provided and are commonly accepted as essential for the type of facility in question.

“Occupancy Level” as referenced in this policy consists of the total licensed beds of a PNMI times the number of days available in the fiscal period (e.g.: A PNMI licensed for 10 beds and open for a full 12 month period, with the fiscal period covering the full 12 months, would have its occupancy level stated at 3650. Ten beds multiplied by 365 days in the year equals 3650 days.)

“Owners” include any individual or organization with equity interest in the provider’s operation and any members of such individual’s family or his or her spouse’s family. Owners also include all partners and all stockholders in the provider’s operation and all partners and stockholders or organizations that have an equity interest in the provider’s operation.

“Per Diem Rate” includes total allowable costs divided by days of care.

“Reasonable Costs” are those incurred by a provider which are reasonable and necessary in providing adequate care to eligible residents and which are within the requirements and limitations of this policy. The reasonableness and necessity of any costs will be determined by reference to, or in comparison with, the cost of providing comparable services.

“Related to the Provider” means that the provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, and supplies.

“Resident” as used throughout this policy refers to the person residing in the facility and is receiving services in the PNMI. The term is also synonymous with “member.”

“Rider A” is used to denote the State’s share of funds used to draw down the federal Medicaid funds by a specific agency/facility. The form states the amount of State money available, the total federal match (Medicaid) that can be drawn down and the combined total (of State and Federal) that the agency/facility can receive in that fiscal year.

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10000 GENERAL DEFINITIONS (cont.)

“State Licensing and Federal Certification” as used throughout these principles are the applicable “Regulations Governing the Licensing and Functioning of Level I Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level II Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level III Private Non-Medical Institutions,” or “Regulations Governing the Licensing and Functioning of Level IV Private Non-Medical Institutions,” “Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services,” “Regulations for Licensing and Certifying of Alcohol and Drug Treatment Services,” or “Rules for the Licensure of Residential Child Care Facilities/Rights of

Recipients of Mental Health Services Who are Children in Need of Treatment;” and the Federal Certification requirements for Private Non-Medical Institutions that are in effect at the time the cost is incurred.

“Leave (bedhold) days” are when the resident is not in the facility and no treatment is provided. Leave days are not a covered service.

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PROC. CODE	DESCRIPTION	MAXIMUM ALLOWANCE
<b>* See Below</b>		
<b>SUBSTANCE ABUSE TREATMENT FACILITIES</b>		
H0010	Detoxification (Non Hospital based)	\$210.96 per diem
H2034	Halfway House Services	\$102.91 per diem
H2036	Extended Care	\$113.38 per diem
H2036 HF	Residential Rehabilitation Type 1	\$217.71 per diem
H2034 HF	Residential Rehabilitation Type II	\$116.07 per diem
H2036 HA	Adolescent Residential Rehabilitation	\$182.04 per diem
T1020 HF	Personal Care - Substance Abuse (Substance Abuse Shelter Services)	\$55.17 per diem

\* Room and Board costs are not reimbursed in the rates for PNMI Substance Abuse Treatment Services

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## INTRODUCTION

### 1000 PURPOSE

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The purpose of Appendix B is to identify reimbursement regulations that are specific to substance abuse treatment facilities under Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. These regulations identify which costs are reimbursable within Section 97, Chapters II and III and Appendix B, Private Non-Medical Institution Services of the MaineCare Benefits Manual. As of November 15, 2010, Substance Abuse Treatment Facilities under this Appendix are reimbursed using a standard rate for each defined type of substance abuse treatment service, and are not subject to establishment of interim rates and cost settlement procedures, as detailed in Section 97, Chapter III. Rates may be found at <http://www.maine.gov/dhhs/audit/rate-setting/index.shtml>.

### 1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds which may be available from State and/or Federal sources for the provision of the services as set forth in Appendix B is contained in 22 MRSA Section 3173-D and Title XIX of the Social Security Act as Amended; 42 U.S.C.A. §1396 et. seq.

### 1210 DEFINITIONS

The term “member” as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving substance abuse treatment by qualified staff of a Private Non-Medical Institution as defined in Section 97.01-1(A) of the MaineCare Benefits Manual.

The term “facility” as used throughout these Principles of Reimbursement refers to private non-medical institutions licensed and funded by the State of Maine, Department of Health and Human Services (DHHS) Office of Substance Abuse Services (OSA) under Sections 4.06, 4.08, 4.09, 4.10, 4.11 and/or 4.13 of the "Regulations for Licensing/Certifying of Substance Abuse Treatment Facilities in the State of Maine," but excludes any Department-licensed facilities staffed by a solo provider.

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2400 SERVICE COMPONENTS OF THE STANDARD RATE

Providers must follow all State of Maine licensing regulations and guidelines for staffing levels and must maintain professional staffing sufficient to serve the individual needs of each recipient as reflected in his individual service plan (as defined in Chapter II, § 97.) Professional services may be provided only within the scope of the professional's license.

2400.1 The standard per diem rates provided for Detoxification (non-hospital based), Halfway House Services, Extended Care, Residential Rehabilitation Services (Type I), Residential Rehabilitation Services (Type II), Adolescent Residential Rehabilitation and Personal Care Substance Abuse (Substance Abuse Shelter Services) are intended to include the service costs listed below. Providers may not bill separately under this section or any other section of the MaineCare Benefits Manual for providing these services. Salaries and wages for direct service staff and services listed below:

Physicians  
Psychiatrists  
Psychologists  
Social workers  
Licensed clinical professional counselors  
Licensed professional counselors  
Registered nurses  
Practical nurses  
Licensed alcohol and drug counselors  
Psychiatric nurses  
Personal care services staff  
Certified interpreters  
Clinical Consultants  
Other qualified alcohol and drug treatment staff as defined in Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.2 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including, but not limited to, utilization data.



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2400 SERVICE COMPONENTS OF THE STANDARD RATE (cont.)

Eff 2/13/11 2410 The rates in this Section include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services. Since providers will no longer receive Rate letters detailing this information, they will need to calculate the service tax at 5% of reimbursed services.

2460 The total costs shall be allocated to rehabilitation and to personal care.

2500 NON-ALLOWABLE COSTS

Non-allowable cost includes all costs not included in Section 2400.

3400 COST REPORTS

3400.1 Uniform Desk Review

3400.11 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded therein, and allowable costs.

3400.13 Based on the results of the uniform desk review, the Division of Audit may:

- a. Request more information,
- b. Issue a final report of findings, or
- c. Conduct a field audit and issue a final report of findings.

5120 PERSONAL CARE SERVICES

PNMI services approved and funded by OSA in licensed facilities may also provide personal care services necessary for the promotion of ongoing treatment and recovery. PNMI facilities must be receiving funds from OSA, specifically for the provision of personal care services, in order to also be reimbursed by MaineCare for such services.

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6000 RATE SETTING

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6000.1

The following capitated rates apply to Appendix B services:

Detoxification (Non Hospital based) - \$210.96 per diem

Halfway House services - \$102.91 per diem

Extended Care - \$113.38 per diem

Residential Rehabilitation Type I - \$217.71 per diem

Residential Rehabilitation Type II - \$116.07 per diem

Adolescent Residential Rehabilitation - \$182.04 per diem

Personal Care Substance Abuse (Substance Abuse Shelter Services) - \$55.17 per diem

Members are assessed as described in Chapter II, Section 97, and assigned to one of the types of substance abuse treatment services described above. Providers bill the Department on a per diem basis for each member receiving service. The capitated rate includes all PNMI services required by the member for his or her type of service including all staffing required pursuant to State of Maine licensing guidelines and as identified in the members individual service plan. There is no cost settlement for Appendix B PNMI services.

6000.2 The provider must submit, upon request, such data, statistics, schedules, or other information required by the OMS and OSA.

6000.3 The standardized rate for each Substance abuse treatment service type will begin November 15, 2010.